PATIENT HISTORY INTAKE

Demographics and Referral

- Child's Name: ____
- Child's DOB: ___________________________
- Child's Address: ____
- Sex: ________________________
- Preferred pronouns: ____
- Person providing information: ____
    - Email: ____
    - Relationship to child: ____
- Reason for referral and who referred: ___________________________________
- Parent main concerns at this time: ____
  ____

Birth History (if known):

- Is child adopted? ________(*If yes, please fill out any known birth or pregnancy history)*
- Pregnancy issues: ______________________________________
- Length of labor: ____
- Place of delivery: ____
- Gestational age at time of birth:_________________________________
- Delivery (C section, vaginal, emergency) ________________________
- Birth weight/length : ________________________
- Assist during birth (forceps, vacuum, etc) _________________________________
- Birth presentation (sunny side up? Cord wrapped anywhere?):
  ____
- Any other issues noted during delivery (brachial plexus injury, collar bone injury, jaundice):
- Did newborn require extended hospital stay? NICU? ______How long? ___________
- Describe interventions provided: ____
- Describe support/monitoring needed upon discharge: ____________________________
- Did baby or mother require extended hospital stay? How long & explain:
  ____ ______________________

Newborn hearing test at birth? Passed? _______ Any follow up needed? _______

Medical History/Systems review

- List any diagnoses your child has: ____
- Vision screening? ___________________
- Immunizations up to date? _______________
- Communicable diseases? ___________________
- Please check any concerns below:
  - Seizures:______ Shunt:_________ Head injury/ Concussion: _____
  - Feeding: _____ Tube:(NG,GT,JT) _____ Aspiration/Pneumonia: _ ____
  - Reflux: __________ Constipation: _____ Gagging/choking: ____________
  - Ear Infections:_____ PE Tubes: _________ Hearing aid/Cochlear Imp: ______
  - Speech delay: ____ loss of words ______ Hard to understand ___________
  -
- Systems check (*please check any areas of concern and explain below)*:
  - Bowel/Bladder:___ Brain:___ Digestion: ___
  - Heart (murmurs,holes,hernia) _______ Respiratory ___
  - Sensory: _____ Skeletal:____ Skin: ____
  - Lungs: _____ Kidney: _____

  Explanations:____

____
- Frequency of BMs:________________________________
- Was baby Jaundice? ______________________________
  - What interventions were required and for how long: __________________________

    ____

- Any other health concerns? ____

- List any tests (swallow study), procedures, hospitalizations, surgeries child has had or is scheduled to have:

  ____

  ____

  ____

- Allergies and sensitivities ____

Gross Motor Milestones Communication Milestones

(please list age milestones were met)

- Holding head up: _____________________ Cooing (vowel sounds) __________________
- Tummy tIme: ________________________ Babbling (consonant sounds)______________
- Rolling back to belly: __________________ Responding to name ____________________
- Rolling belly to back : __________________ Following simple directions ______________
- Sitting alone: ________________________ Imitating sounds _______________________
- Crawling on belly: ____________________ Saying single words ______________________

- **Crawling on hands and knees: __________**
- **Pulling to stand: ______________________**
- **Cruising :_____________________________**
- **Standing: ______________________________**
- **Walking without support: _______________**

Saying phrases __________________________
Saying Sentences ________________________

Therapies

- **List any previous therapies: ____**
- **List any current therapies: ____**

Other professionals involved with your child

- **Allergist:____**
- **Chiropractor: ____**
- **CST:____**
- **Dentist: ____**
- **Doula: ____**
- **ENT: ____**
- **GI: ____**
- **Lactation Consultant: ____**
- **Neurologist: ____**
- **Nutritionist/Dietician: ____**
- **Orthopedist: ____**
- **Pediatrician: ____**
- **Specialists: ____**
- **Therapists: ____**
- **Other: ____**

Medications:

Please list all medications (include dosage and purpose of med) your child is currently taking:

____
____
____
____

Daily Life

- **List all the people living in your home: ____**
  ____

- **School/Education/Regular child care situation**
  - **Home with Caregiver: ___________________________**
  - **Daycare: ______________________________________**
  - **School: ____**